

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address STAT 2000 P.O. Box 15640 Fort Worth, TX 76119-5640	MDR Tracking No.: M4-04-4361-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Texas Association of Counties Hammerman & Gainer	Date of Injury:
	Employer's Name: Dimmit County
	Insurance Carrier's No.: TCTAC 91C 6307

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/28/02	08/28/02	E1399 Large Electrode Belt	\$249.00	\$249.00
Total Amount Due				\$249.00

PART III: REQUESTOR'S POSITION SUMMARY

The dispute was originally sent on 11/12/02 via certified mail and received by TWCC on November 15, 2002. Reply not received so another certified copy was sent on 12/30/02 and received by you on 1/3/03. There was a question as to whether this was a federal claim. TWCC has not established a MAR for this product. A detailed merchandise description is provided to better aid in determining appropriate reimbursement. Audit sheets or copies of other carrier checks also provided to show that other carrier's have paid and find \$495.00 a fair and reasonable charge for the large Electrode Belt.

PART IV: RESPONDENT'S POSITION SUMMARY

The EOB denial reason states; "Reconsideration denied – we checked with other companies that bill for large electrode belt and they were not as high as your company. Our F/R stays at \$246.00." The Response indicates that payment was made based on the medical fee guidelines and TWCC rules and that the request should be dismissed on the basis that it was not timely filed with the Commission. There is also a statement on the Table of Disputed Services that says "F" – Reduced accd'g to fee guidelines. Per DME GR, IX-C; if there is no pre-negotiated amt., the F+R rate. A F+R rate shall be the same as the fees set for the "D" Codes in the 91 MFG. Carrier researched other companies and determined that the F&R price was 246.00."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The requestor has established that the TWCC-60 Request for MDR was timely received by TWCC on 11/15/02. Therefore this dispute is timely.

The Respondent asserts that it's research lead them to a reduced amount of reimbursement based on what other companies have billed. However, that research or other billing information was not received. It could not be determined whether that research involved comparison of the same or similar item that provided the same medical benefit.

Review of the Medicare and Palmetto website also provided no reference to similar items for which a reasonable reimbursement could be determined. On this basis, as there is no set MAR in the Commission's Fee Guidelines and no supporting research from the carrier to support the alternative reimbursement amount, the Requestor has proved the Respondent's reimbursement amount is not fair and reasonable. Additional reimbursement as indicated above is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$249.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Patti Lanfranco

July 29, 2005

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____